APPLICATION FORM
Cities Area Transit (CAT)
Special Transportation Services for Persons with Disabilities

This application form is used by Cities Area Transit to determine an individual with disabilities eligibility for CAT Paratransit and/or half-fare on CAT Fixed Route Bus System in the cities of Grand Forks, North Dakota and East Grand Forks, Minnesota. If you have any questions, contact the Transit Office listed below.

Senior citizens who are not people with disabilities should complete a different application form for senior discounts and services.

MAIL ORIGINAL COMPLETED APPLICATION FORM TO:
Cities Area Transit
Attn: Paratransit
PO Box 5200
Grand Forks, ND 58206-5200

Complete all parts of the form clearly and legible. Forms that are not fully completed and/or legible will be returned, which will delay your eligibility determination. The applicant will receive a written determination of acceptance or denial of eligibility (by mail) within 21 calendar days following receipt of a completed application and professional verification form.

Last Name ________________________________
First Name ________________________________ Middle Initial____
Maiden Name (If applicable) ________________________________
Address ___________________________________________________________________
____________________________________________________________________________
City ___________________________ State _______ Zip _______
Daytime phone: ________________ Evening phone: ________________
Applicant’s Date of birth: ______/_____/______
Do you have a Medicare card? Yes _____ No ______
List the name of one person or agency that we may contact in the case of an emergency: (This is optional and is not required.)

Name: ______________________________________________________________
Address: ______________________________________________________________
Daytime phone: _________________  Evening phone: _________________

1. Are you a:  ___Current Paratransit Rider  ___New Applicant

2. Do you need information given to you in another format?
   ___Yes  ___No
   ___Large Print  ___Audio Tape  ___CD  ___Braille  ___Another Language

3. Are you able to travel in an automobile?  ___Yes  ___No

4. Do you use a wheelchair or scooter: ___Yes  ___No  If yes,
   Is it more than 30 inches wide?
     ___Yes  ___No
   Is it more than 48 inches long?  (Measured 2-inches from the floor)
     ___Yes  ___No
   Is the combined weight of device and occupant more than 600 lbs.?  
     ___Yes  ___No
   If you use a wheelchair or scooter, what is the combined weight of the 
   occupant and the wheelchair or scooter?  _____________ pounds.

5. Does your health condition/disability require you to use Dial-A-Ride Services
   ___ Seasonally (Nov. – April)
   ___ Permanently
   ___ Temporarily (if so, for how long)?  ___Week(s)  ___Month(s)

6. When using DAR Service, does your health condition/disability require you to travel with someone to assist and/or supervise you?  ___Yes  ___No
7. Do you have a physical or mental impairment?
   ___Physical  ___Mental  ___Both
   Please describe your disability? __________________________________________

8. How does this disability prevent you from using CAT Fixed Route Services? Please explain completely. Use an additional sheet if needed.
   _______________________________________________________________________
   _______________________________________________________________________

9. Which of the following assistive devices, if any, do you use? (Please check all that apply).

   ___ Cane  ___*Powered Wheelchair  ___Transfer Board
   ___ White Cane  ___ Manual Wheelchair  ___ Prosthetic
   ___ Walker  ___*Powered Scooter/Cart  ___ Communication Aid
   ___ Crutches  ___ Portable Oxygen  ___ Life Support Equipment

   ___ Service Animal (please describe): ________________________________
   ___ Other (please describe): ________________________________________

*If you selected wheelchair or scooter, would you prefer/need to use the device while riding in paratransit vehicles?
PART 2: Questions about using regular-route public transit

Complete Part 2 even if you are unable to use regular-route city bus service. This information will assist us in determining how your disability/health condition affects your ability to use regular-route city bus services.

10. Do you now independently use regular-route city buses?
   ___Yes    ___No    ___Sometimes
   If “yes” or “sometimes,” how many times?
   ____per week   ____per month   ____per year

   If “no”, please explain what prevents you from independently using regular-route city bus. ____________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

11. Which of the following best describes how you use regular route city buses?
    ____To travel to and from one destination only
    ____To travel to and from a few destinations
    ____To travel to and from many different destinations

12. Have you ever had training to use the regular route city buses?
    ___Yes    ___No  If no, would you like training. ___YES

13. Using a mobility aid or on your own, how far are you able to travel without the assistance of another person?
    ____3 blocks    ____6 blocks
    ____9 blocks or more    ____less than 3 blocks

14. I can wait for a regular-route city bus (check all that apply):
    ____only if there is a bench or shelter
    ____up to 15-minutes       ___More than 15 minutes
15. Will you regularly need driver assistance to/from the bus or van? 
   ___ Yes  ___ No  If yes, please explain: ____________________________

16. Does temperature or weather affect your disability? 
   ___ Yes  ___ No  If yes, please explain: ____________________________

17. Can you climb steps without assistance? 
   One 12-inch step ___ Yes  ___ No  Sometimes (explain) ____________________________
   Three 12-inch steps: ___ Yes  ___ No  Sometimes (explain) ____________________________

18. Can you wait outside without support for ten minutes? 
   ___ Yes  ___ No  Sometimes (explain) ____________________________

19. Do you have a mental or psychological disability?  ___ Yes  ___ No

20. Are you sight-impaired or legally blind?  ___ Yes  ___ No

21. Are you able to:
   Give addresses and telephone numbers upon request 
   ___ Yes  ___ No  ___ Sometimes (explain): ____________________________
   Recognize a destination landmark? 
   ___ Yes  ___ No  ___ Sometimes (explain): ____________________________
   Deal with unexpected situations or unexpected change in route? 
   ___ Yes  ___ No  ___ Sometimes (explain): ____________________________
   Ask for, understand and follow directions? 
   ___ Yes  ___ No  ___ Sometimes (explain): ____________________________
   Safely and effectively travel through crowded and/or complex facilities? 
   ___ Yes  ___ No ___ Sometimes (explain): ____________________________
The information provided on this form is private data and is used to determine ADA Paratransit eligibility. The ability to determine your eligibility is based on receiving all of the information requested on this form. All medical and personal information pertaining to applications for users of ADA paratransit service is private, except the name of the applicant or user. Any other information cannot be released to anyone else, unless the applicant or user authorizes the release in writing. If you are determined ADA Paratransit eligible, information about your eligibility status will be entered into a database maintained by Cities Area Transit.

I certify that all the information on this application form is true and correct. I understand that misinformation or misrepresentation of facts will be cause for disqualification or rejection of my ADA eligibility. I also understand that additional information relating to my health condition or disability may be required to determine eligibility. I understand that I am responsible for authorizing health care professional verification of my condition(s) and that an in-person evaluation may be requested.

________________________________________
APPLICANTS SIGNATURE

________________________________________
DATE

*If the applicant is not his/her own guardian, the following information about the guardian is required.

Guardian’s Name: __________________________________________
(Print) First Middle Initial Last

(____) __________________________
Day Phone

________________________________________
Guardian’s Signature

Date

*If someone other than the applicant or the applicant’s guardian is preparing this form, please provide the following information about the preparer:

Preparer’s Name: __________________________________________
(Print) First Middle Initial Last

(____) __________________________
Day Phone

________________________________________
Preparer’s Signature

Date
AUTHORIZATION RELEASE FORM

Name of Applicant: __________________________________________
(Please Print)

I authorize the following professional to release to the Cities Area Transit specific information as requested. It is my understanding that the information released will be used solely to determine my ADA Paratransit eligibility. I understand that I may revoke this authorization at any time. Unless revoked, this form will allow that professional listed below to release information described for six months after the date appearing below.

The person listed below is familiar with my disability and is authorized to provide information to Cities Area Transit to determine my qualifications for special transportation services.

**FILL IN THE FOLLOWING INFORMATION ON A PHYSICIAN OR PROFESSIONAL WHO IS FAMILIAR WITH YOUR DISABILITY -- PLEASE PRINT**

The individual listed below is a:

| ___ Licensed Physician | ___ Certified Psychologist |
| ___ Licensed Physician Assistant | ___ Certified Psychiatrist |
| ___ Certified Rehabilitation Specialist | ___ Mental Health Counselor |
| ___ Licensed Social Worker | ___ Licensed Physical Therapist |
| ___ Nurse (LPN or RN) | ___ Licensed Ophthalmologist |
| ___ Respiratory Therapist | ___ Certified Audiologist |
| ___ Registered Occupational Therapist | ___ Other (Specify) __________ |

Physician or Professional's Name __________________________________________

Clinic or Business Name __________________________________________

Address __________________________________________

City __________________ State _____ Zip __________

Telephone Number (Work) __________________________

Signature of Applicant: __________________________

Date ___/___/_____


NOTE: Any medical fees associated with providing this information is the responsibility of the applicant or client and not the Cities of Grand Forks, ND, East Grand Forks, MN; or Cities Area Transit.
OPT-IN TO RECEIVE AUTOMATED NOTIFICATIONS

Name of Applicant: __________________________________________

(Please Print)

Cities Area Transit offers automated telephone notifications for Dial-A-Ride and Senior Rider users. These notifications assist with communicating with passengers regarding scheduled rides, delays, and important service announcements. You may choose not to receive any automated notifications by checking the following box and signing below:

___ I do not wish to receive any automated notifications

OR

You may opt-in to receive automated notifications by checking the applicable boxes and signing below.

I authorize Cities Area Transit to make automated telephone notifications for the following purposes (check all that apply):

___ Next-day reservation reminders

___ Estimated time of arrival notices (15 minutes in advance)

___ Service announcements (i.e. changes or closures due to inclement weather, holidays, etc.)

Please provide one phone number for notifications: ___________________

Signature of Applicant:

__________________________________________ Date ___/___/___